MEDICAL BOARD OF CALIFORNIA

Peer Review Body Initial Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician

Name of Physician: _____ Medical License #: _____
Specialty: _____
Office Address: _____
_____ Telephone #: _____

Name of Reporting Entity: _____

Address: _____

Contact Person: _____ Telephone #: _____
(Please Print Name and Title)

Briefly Describe the reason for the investigation, including why a mental or physical disorder that may pose a threat to patient care is suspected: _____

Proposed Time Line for Investigation: **Date:**

1. Initiate Formal Investigation. _____
2. Gather Facts about the Problem. _____
   Must be completed within 30 days of Date Formal Investigation Initiated.
3. Request Psychiatric and/or Physical Evaluation, if appropriate. _____
4. Review Findings and Make Decision Regarding Disposition of Case. _____
   Must be completed within 45 days (if no evaluation necessary) or within 75 days (if evaluation(s) necessary) of Date Formal Investigation Initiated.
5. Inform MBC and Physician of Investigation Outcome. _____
   Must be completed within 15 days of Disposition Decision.

_____

Signature Date Signature Date
C.E.O./ Medical Director/ Administrator Chief of Medical Staff (if any)

_____ _____

Print Name and Title Print Name and Title

Note: The information requested on this form is per authority of Section 821.5 of the Business & Professions Code.

MEDICAL BOARD OF CALIFORNIA

Peer Review Body Final Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician

Name of Physician: _____ Medical License #:_____
Specialty:_____
Office Address:_____

Name of Reporting Entity: _____
Address:_____
Contact Person:_____Telephone #:_____
(Please Print Name and Title)

Disposition of the Case:

1. No Problems Exist.____ Explain _____

2. These Problems Exist (indicate mental or physical disorder diagnosis, if applicable):_____

3. If a Mental or Physical Disorder exists, is there a threat to patient care? _____ Explain _____

4. The following Action Plan has been implemented: Check all that apply:

a. The physician is undergoing treatment for the disorder. Explain. _____

b. The physician will be monitored. Describe monitoring plan _____

c. Practice restrictions or conditions have been summarily imposed. Explain. _____

d. Practice restrictions or conditions have been recommended and the physician has been offered a hearing under B&P Code Section 809.1. Explain. _____

e. An 805 Report has been filed. Explain. _____

f. Other. Explain. _____

Signature C.E.O./ Medical Director/ Administrator	Date	Signature Chief of Medical Staff (if any)	Date
Print Name and Title		Print Name and Title	

Note: The information requested on this form is per authority of Section 821.5 of the Business & Professions Code